

Appendix 11b ▪ Deinstitutional Services Assessment

Resident's Name:		Date:	
Address:		Date of Birth:	
		Age:	
Phone:	Marital Status:	Race:	
Educational Level:	Primary Language:	Translation to be provided by:	
Interview participants other than resident:			
Insurance Information:			
SSN:		Medicare/RRB #:	
Medi-Cal#		Other Insurance:	
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Conservator	<input type="checkbox"/> Durable Power of Attorney	Translator needed? <input type="checkbox"/> Y <input type="checkbox"/> N
Name:			
Address:			
Phone:			
Emergency:		Phone	
Name:			
Address:			
Relationship to Resident:			
Physician:		Phone	
Name:			
Address:			
Referral Source:			

Section 1: Diagnoses

Diagnoses: Check diagnosis here if (1) It is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing facility admission forms, etc.), or (3) if resident or informant can state it. Note source in Comments section. Statements should be confirmed by resident's medical records.

A. Endocrine/Metabolic:	Comments
<input type="checkbox"/> Dehydration/Fluid & Electrolyte Imbalances <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypothyroidism/Hyperthyroidism <input type="checkbox"/> Liver Disease (Hepatic Failure, Cirrhosis) <input type="checkbox"/> Nutritional Imbalances (e.g., Malnutrition, Vitamin Deficiencies, High Cholesterol, Hyperlipidemia) <input type="checkbox"/> Other Disorders Of Digestive System (Mouth, Esophagus, Stomach, Intestinos, Gall Bladder, Pancreas)	

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<input type="checkbox"/> Other Disorders of Hormonal or Metabolic System	
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B. Heart/Circulation:	Comments
<input type="checkbox"/> Anemia/Coagulation Defects/Other Blood Diseases <input type="checkbox"/> Angina/Coronary Artery Disease/Myocardial Infarction (MI) <input type="checkbox"/> Congestive Heart Failure (CHF) <input type="checkbox"/> Disorders of Blood Vessels or Lymphatic System <input type="checkbox"/> Disorders of Heart Rate or Rhythm <input type="checkbox"/> Hypertension (HTN) (High Blood Pressure) <input type="checkbox"/> Hypotension (Low Blood Pressure) <input type="checkbox"/> Other Heart Conditions (Including Valve Disorders)	
C. Musculoskeletal/Neuromuscular:	Comments
<input type="checkbox"/> Amputation <input type="checkbox"/> Arthritis (e.g., Osteoarthritis, Rheumatoid Arthritis) <input type="checkbox"/> Contractures/Connective Tissue Disorders <input type="checkbox"/> Hip Fracture/Replacement <input type="checkbox"/> Multiple Sclerosis/ALS <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoporosis/Other Bone Disease <input type="checkbox"/> Paralysis Other Than Spinal Cord Injury <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Other Chronic Pain/Fatigue (e.g., Fibromyalgia, Migraines, Headaches) <input type="checkbox"/> Other: Fracture/Joint Disorders/Scoliosis/Khyphosis <input type="checkbox"/> Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders	
D. Brain/Central Nervous System:	Comments
<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Vascular Accident (CVA, stroke) <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other Brain Disorders <input type="checkbox"/> Other Dementia	
E. Respiratory:	Comments
<input type="checkbox"/> Tracheotomy <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia/Acute Bronchitis/Influenza <input type="checkbox"/> Ventilator Dependent <input type="checkbox"/> Other Respiratory Condition	
F. Disorders of Genitourinary/Reproductive Systems:	Comments
<input type="checkbox"/> Incontinence <input type="checkbox"/> Renal Failure, Other Kidney Disease <input type="checkbox"/> Testicular/Prostate Problems <input type="checkbox"/> Urinary Tract Infection (UTI), Current or Recently Recurrent <input type="checkbox"/> Vaginal Problems <input type="checkbox"/> Other Disorders of GI System (Bladder, Urethra)	

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G. Documented Mental Illness: <input type="checkbox"/> Anxiety Disorder (e.g., Phobias, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder) <input type="checkbox"/> Bipolar/Manic-Depressive <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other Mental Illness Diagnosis (e.g., Personality Disorder)	Comments
H. Sensory: <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Hard Of Hearing <input type="checkbox"/> Visual Impairment (e.g., Cataracts, Retinopathy, Glaucoma, Macular Degeneration) <input type="checkbox"/> Other Sensory Disorders	Comments
I. Infections/Immune System: <input type="checkbox"/> AIDS (Diagnosed) <input type="checkbox"/> Allergies <input type="checkbox"/> Auto-Immune Disease (Other Than Rheumatism) <input type="checkbox"/> Cancer in Past 5 Years <input type="checkbox"/> Diseases of The Skin <input type="checkbox"/> HIV Positive <input type="checkbox"/> Other Infectious Disease	Comments
J. Other: <input type="checkbox"/> Alcohol or Drug Abuse <input type="checkbox"/> Behavioral Diagnoses (Not Found in Part G Above) <input type="checkbox"/> Terminal Illness (Prognosis \leq 12 Months) <input type="checkbox"/> Wound, Burn, Bedsore, Pressure Ulcer <input type="checkbox"/> Other: Specify	Comments

Section 2: Health-Related Services
Check only one box per row:

Health-Related Services Needed	Person is Independent	Current Frequency Of Help/ Services Needed From Other Persons						Comments: Any changes anticipated by date of discharge. Specify who will assume current help activities and source of payment, if any.
		1 to 3 times/ month	Weekly	2 to 6 times/ week	1 to 2 times/ day	3 to 4 times/ day	Over 4 times/ day	
Interventions related to Behaviors								
CONDITION – REQUIRES NURSING ASSESSMENT or skilled medical monitoring by persons trained and overseen by nurse. Condition may be unstable or deteriorating (e.g., infections, gangrene, dehydration, malnutrition, terminal condition, exacerbation, AIDS) and/or result from multiple health risks in person unable to manage them or to communicate problems.								
IV CHEMOTHERAPY								
EXERCISES/RANGE OF MOTION								
IV FLUIDS								
IV MEDICATIONS (Drips or boluses, not chemotherapy)								
MEDICATION ADMINISTRATION (not IV) OR ASSISTANCE with pre-selected or set-up meds								
MEDICATION MANAGEMENT – Set-up and/or monitoring (for effects, side effects, adjustments) AND/OR blood levels								

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Health-Related Services Needed	Person is Independent	Current Frequency Of Help/ Services Needed From Other Persons						Comments: Any changes anticipated by date of discharge. Specify who will assume current help activities and source of payment, if any.
		1 to 3 times/month	Weekly	2 to 6 times/week	1 to 2 times/day	3 to 4 times/day	Over 4 times/day	
OSTOMY-RELATED <u>SKILLED</u> SERVICES								
OXYGEN								
PAIN MANAGEMENT								
POSITIONING IN BED OR CHAIR every 2-3 hours								
RESPIRATORY TREATMENTS: Nebulizers, IPPB Treatments, BI-PAP, C-PAP (does NOT include inhalers)								
IN-HOME DIALYSIS								
TPN (Total Parenteral Nutrition)								
TRANSFUSIONS								
TRACHEOSTOMY CARE								
TUBE FEEDINGS								
ULCER – Stage 2								
ULCER – Stage 3 or 4								
URINARY CATHETER-RELATED <u>SKILLED</u> TASKS (irrigation, straight catheterizations)								
OTHER WOUND CARE (not catheter sites, ostomy sites, or IVs)								
VENTILATOR-RELATED INTERVENTIONS								
OTHER (specify):								
		5+ DAYS/WEEK			1 TO 4 DAYS/WEEK			
<u>SKILLED THERAPIES:</u> PT, OT, Speech. Other (specify).								

Section 3: Planning Issues For Health

Priorities and Support Needs	Comments: What needs to be done, when, by whom
<input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Community Doctor <input type="checkbox"/> Dentist <input type="checkbox"/> Evaluations (OT, Hearing, Vision, etc.) <input type="checkbox"/> Exercise <input type="checkbox"/> Medical Supplies <input type="checkbox"/> Preventative Health Care <input type="checkbox"/> Pharmacy <input type="checkbox"/> Pain Management <input type="checkbox"/> Specialist <input type="checkbox"/> Therapy <input type="checkbox"/> Other:	
Resources <input type="checkbox"/> Own Equipment <input type="checkbox"/> Other:	

Section 4: Planning Issues for Housing

Priorities	Comments: What needs to be done, when, by whom
<input type="checkbox"/> Access to Home <input type="checkbox"/> Access To Rooms <input type="checkbox"/> Appliances <input type="checkbox"/> Bathroom Modifications <input type="checkbox"/> Change Of Address <input type="checkbox"/> Equipment <input type="checkbox"/> Furniture <input type="checkbox"/> Independent Housing <input type="checkbox"/> Keys For Care Providers <input type="checkbox"/> Kitchen Modifications <input type="checkbox"/> Location <input type="checkbox"/> Pet Accommodations <input type="checkbox"/> Shared Housing <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Telephone <input type="checkbox"/> Utilities <input type="checkbox"/> Other:	
Resources <input type="checkbox"/> Donated Funds <input type="checkbox"/> Donated Furniture <input type="checkbox"/> Independent Living Center <input type="checkbox"/> Own Furniture <input type="checkbox"/> Service Clubs (E.G., Kiwanis, Rotary) <input type="checkbox"/> Subsidy Programs e.g., LIHEAP, Section 8) <input type="checkbox"/> Other:	

Section 5: Planning Issues for Financial Matters

Priorities	Comments: What needs to be done, when, by whom
<input type="checkbox"/> Credit History May Be Problematic <input type="checkbox"/> Current Bills/Debts That Require Action <input type="checkbox"/> Determine Amount And Sources Of Income <input type="checkbox"/> Develop A Budget <input type="checkbox"/> Eligibility For Food Stamps <input type="checkbox"/> Establish Bank Account <input type="checkbox"/> Establish Direct Deposit <input type="checkbox"/> Money Management Services <input type="checkbox"/> Other:	
Resources <input type="checkbox"/> Family Support <input type="checkbox"/> Other Pension <input type="checkbox"/> Personal Savings <input type="checkbox"/> Social Security <input type="checkbox"/> SSI <input type="checkbox"/> VA <input type="checkbox"/> Other:	

Section 6: Planning Issues for Independence/Self-Determination

Priorities	Comments: What needs to be done, when, by whom
Assistance With: <input type="checkbox"/> Back-Up Plan For Emergencies <input type="checkbox"/> Decision-Making <input type="checkbox"/> Emotional Support <input type="checkbox"/> Communication Equipment <input type="checkbox"/> Health Care Advocate <input type="checkbox"/> Support Group <input type="checkbox"/> Legal Advice <input type="checkbox"/> Living Will <input type="checkbox"/> Memory <input type="checkbox"/> Power Of Attorney <input type="checkbox"/> Record Keeping <input type="checkbox"/> Other:	
Previous Experience; contact With Community Agencies (e.g., IHSS, APS); nature of this experience:	
Resources <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Independent Living Center <input type="checkbox"/> Religious/Spiritual Group <input type="checkbox"/> Social Clubs <input type="checkbox"/> Other:	

Section 7: Planning Issues for Social and Recreational Needs

Priorities <input type="checkbox"/> Ethnic/Cultural Traditions <input type="checkbox"/> Future Events to Plan for (Birthdays, Holidays, Etc.) <input type="checkbox"/> Hobbies (Either To Maintain Or Develop) <input type="checkbox"/> Meet Neighbors <input type="checkbox"/> Private Time <input type="checkbox"/> Peer Support <input type="checkbox"/> Religious/Spiritual Affiliation <input type="checkbox"/> Phone Calls <input type="checkbox"/> Visits From Friends/Family <input type="checkbox"/> Other:	Comments: What needs to be done, when, by whom
Resources <input type="checkbox"/> Family/Friends <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Place Of Worship <input type="checkbox"/> Volunteer Opportunities <input type="checkbox"/> Other:	

Section 8: Planning Issues for Transportation

Priorities <input type="checkbox"/> Mobility Training <input type="checkbox"/> Will Require Escort <input type="checkbox"/> Routine Transportation (e.g., Bus, Taxi, Dial-A-Ride) (Schedules, Tokens/Scrip) <input type="checkbox"/> Transportation From NF To New Residence (Self & Belongings) <input type="checkbox"/> Other:	Comments: What needs to be done, when, by whom
Resources <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Own Vehicle <input type="checkbox"/> Public Program (e.g., Paratransit Discount) <input type="checkbox"/> Volunteer <input type="checkbox"/> Other:	